CALIFORNIA STATE DEPARTMENT OF PUBLIC HEALTH
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Weekly Bulletin

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*The Public Health Nurse in the Venereal Disease Program**

By LUELLA MCCARTHY, Public Health Nurse, Bureau of Venereal Diseases, State Department of Public Health

As a public health nurse in the venereal disease control program it is proposed to discuss the relationships and responsibilities of the nurse to the patient as a part of the family and the community, and to the physician who carries so important a role in the program.

The word nurse connotes to a vast majority of the American people two things, each very important: (1) the physician's assistant and (2) a friend in time of need. Through her close relationship to the physician and through the friendly services she has been able to render, she frequently is the recipient of confidences which would be withheld from others.

It is vitally important that the public health nurse at all times maintain her integrity in upholding this confidence, be it clinic or private patient. She must approach her work with respect for the freedom of the individual, the sanctity of the family, and a belief in the innate desire of each person to become a self-respecting, healthy citizen. A fundamental knowledge of the public health point of view and procedure must be supplemented with an understanding of social problems and the use of community resources to make her work most effective.

The program for venereal disease control has been described under three heads: (1) education, (2) investigations, and (3) treatment. Gladys Crain, Epidemiologist Massachusetts Department of Public Health, specifies as definitely within the nurse's province under these heads the following:

EDUCATION:

1. Assisting with case holding by seizing every opportunity to clarify the situation in which the patient with syphilis or gonorrhea finds himself. This may be an interpretation of diagnosis; an explanation of the reasons for the arduous treatment regime; an exposition of the why's and wherefore's of clinic procedure, or encouragement by reemphasizing the hope for cure. The control of syphilis or gonorrhea depends, in the last analysis, upon a well-informed patient.
2. Assisting with general community education by being prepared to give satisfactory information to those who inquire about the diseases and the control program and to those who need to be set right regarding fallacies, misunderstandings or unfounded prejudices.

INVESTIGATIONS:

1. Assisting with tracing the sources of infection.
2. Making arrangements for family contact examinations as she arranges for many other health emergencies.
3. Assisting with the discovery of the unsuspected case by the unfailing recognition of danger signals whether in health histories or the patient himself, and by implanting a desire for medical

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attention in all who show deviations from accepted health norms.

TREATMENT:

1. Sharing with patients who need medical attention a knowledge of hospitals, clinics or private physicians where such treatment may be obtained.
2. Making definite arrangements for such medical examination or treatment.
3. Recognizing other health and social needs in families where syphilis or gonorrhea is present, and through cooperative agency planning, assisting with the removal or alleviation of conditions which hinder effective treatment and efficient living.

The nurse has two fields of work: (1) with clinic patients and (2) with those of private practice.

In the clinic, her work is simplified to a certain extent because the enrollment of the patient is in itself an expression of his concern about his condition. The nurse cooperating with other clinic personnel establishes constructive contact which will be the foundation for case-holding. Once the patient has been convinced that he and his personal difficulties are regarded as individual problems the basis for further constructive work may be established. The nurse helps him to understand the reasons for precautions against infections and helps him to adjust necessities to present environment. The interview prepares and often completes the necessary arrangements for the examination of contacts. It should create a desire for regular and continuous treatment. The patient should be aware of the nurse's willingness to discuss his difficulties with him, at any time, without the formality of an appointment.

As an aid to the clinic physician the nurse may take social histories, make investigations regarding previous treatment, assist in the transfer of patients to private practice or to other clinics when occasion indicates. At his request, she may make home visits to demonstrate procedure or to clarify reasons for difficulties encountered.

The nurse has a special opportunity in her interview with the private physician. Busy though he may be, he never is too busy to listen courteously and carefully if the nurse has a real message for him. He has always proved to be anxious to cooperate when he is given definite ways in which he may do so. True, he may complain a bit at first about all the red tape involved, such as getting birth dates, but he usually voluntarily offers the suggestion that it would be no great hardship to obtain such information at a first interview if he acquires the habit of asking for this information. He is always interested to know that he may receive free blood tests for pregnant women and for all other patients, as diagnostic service in routine physical exminations, if the patient is unable to afford the regular laboratory fee.

Responses to the nurse's offer in a confidential capacity to follow up lapsed or prematurely terminated cases is meeting with a growing response. At first the physician may offer only such cases as have long since dropped out of the picture or have been so irregular in attendance that he has lost much of his initial enthusiasm for that particular case. If the nurse is able to demonstrate her ability to cooperate at this point, she has helped cement the confidence the physician placed in her when he first gave her the commission. Each similar encounter should be a building stone toward the point where he will ask her assistance in bringing known contacts and sources who have failed to respond to the patient's invitation for examination. We constantly reiterate that we are endeavoring to keep the known 75 per cent of our cases under private physician's care. Here is a big opportunity for the nurse to show she is able to gain the patient's confidence, discover the real cause of treatment lapse, and assist in adjusting the situation to the satisfaction of all concerned.

Physicians have been glad to read loan copies of the rules and regulations for health officers as adopted by the State Board of Public Health. The ten-page circular is so well written he may with a minimum of time find the exact ruling he desires.

Literature appropriate to each case is mailed when Form VC 10 is sent in acknowledgment of his report. Physicians are requesting additional copies to keep in their reception halls. Requests have been met for literature on modern procedure in the treatment of syphilis and literature pertaining to drugs used.

A sincere effort is made to find the solution for unusual situations presented by the physician. Those things which lie outside the nurse's province are referred to the health officer.

Because of the intricacies of the nurse's duties, errors may occur. When the nurse committing error, however unwittingly, goes unhesitatingly to the physician, frankly acknowledging the mistake, she finds him more than willing to meet her half way. Sincere, obtrusive but cooperative effort, is the nurse's keynote.

While accepting the responsibilities of her position, the public health nurse calls for assistance from her official superiors and the physicians with whom she works. She invites suggestions and criticisms of the present program so she may better serve her community.

The nurse's function is two-fold.

1. To represent the health department to the physician and community.
2. To represent the physician to the patient or prospective patient when clinical or epidemiological relationships are involved.

In this capacity the public health nurse assists in disseminating information, in her investigative work she assists in expanding the program, and through her cooperation with clinician and agency coordinates and "lubricates" established procedures upon which the program must depend in order to succeed and in the treatment phase of her work she is endeavoring constantly to extend the therapeutic program whether in public agency or private office.

DOCTOR KRESS RESIGNS FROM BOARD

In order to devote his full time to newly assumed duties as secretary of the California Medical Association, Dr. George H. Kress, of Los Angeles, has resigned his membership on the California State Board of Public Health.

Dr. Kress was appointed to the board in 1933 and has served continuously since that time. He has been editor of California and Western Medicine for many years and will continue in that capacity in addition to his secretaryship of the medical association. The duties of his office will demand that most of his time be spent in the San Francisco offices of the California Medical Association.

"Poor posture" is a sign that the child needs a careful and complete medical examination to discover the underlying cause of poor posture. The "poor posture," like toothache, is really nature's warning that something is wrong and the child needs the physician's help to discover what that "something" is and to tell him how to correct it. When the cause is removed or corrected, the poor posture usually disappears. Treat the child, not the posture.

Some of the grotesque attitudes in which children sit or lie have a real purpose back of them, for they relax the child's tired muscles and let him "rest up" most quickly.—LeRoy A. Wilkes, M.D.

The joy of creation is so exalted that it has been called divine. Next to it is the joy of coming to know what has been wrought and thought by the most highly endowed members of the race. Through them and their achievements we discern powers and qualities latent within ourselves. The more we understand, the more we appreciate and the richer life becomes.—Leon J. Richardson.

COMMUNICABLE DISEASES IN AUGUST

Typhoid Fever. As is usual at this season of the year, typhoid fever shows an increase. During August, cases were investigated by the State Department of Public Health in six counties of the state. Many cases were found in migratory agricultural camps. While the numbers of cases in the various counties were low, the distribution was quite extensive.

Smallpox. There were thirty-eight cases of smallpox recorded in August. The incidence of the disease is higher than usual, indicating the need for continued immunization procedures.

Malaria. Two distinct outbreaks of malaria have occurred during recent weeks—one in the Federal Migratory Camp near Winters and the other in Tulare County. In the Yolo Camp many of the residents were from the southern states. It would appear that malaria is being brought into California from malarious districts in the dust-bowl area.

Relapsing Fever. Three cases of this disease in one Los Angeles family were investigated. Infection was contacted at a high elevation in the Sierra. Two cases, similarly contacted, were investigated in Orange County. Wild rodents have been proven to be the reservoir of infection and the tick the vector. The disease has appeared recently in the San Benito Mountains of the coast range.

Encephalitis. Investigations into epidemic encephalitis were made in Butte, Sacramento, Madera, Fresno, Tulare, and Kern counties. These cases resembled the St. Louis type of the disease. The mortality rate is low and clinically the cases appear to be milder than last year.

Psittacosis Control. In Southern California 79 shell parrakeet aviaries were inspected and 228 insterstate shipments were checked and approved. These shipments involved 3292 shell parrakeets and 296 larger psittacine birds.

General Health Conditions. Epidemic poliomyelitis is unusually low this year. There were but twenty-nine cases reported during August. A considerable number of cases of food poisoning occurred during August, eighty-nine cases having been reported. Malaria showed an increase due to outbreaks among migratory laborers. Other reportable diseases are at normal status for this season of the year.

Do not spend your days waiting for an angel to deliver realized hopes at your door. Go out and toil for them. There are few forms of hard work more wearying than waiting.

MORBIDITY

Complete Reports for Following Diseases for Week Ending September 17, 1938

Chickenpox

103 cases: Alameda County 2, Albany 1, Berkeley 8, Oakland 19, Fresno County 1, Los Angeles County 1, Alhambra 1, Long Beach 1, Los Angeles 21, Santa Monica 2, Salinas 1, Santa Ana 1, Riverside 1, Sacramento County 3, Sacramento 2, Ontario 1, National City 4, San Diego 3, San Francisco 18, San Joaquin County 1, Stockton 1, San Luis Obispo 2, Santa Barbara 1, Santa Clara County 1, Palo Alto 2, Tulare County 3, Ventura 1.

Diphtheria

30 cases: Oakland 5, Kern County 1, Los Angeles County 2, Arcadia 3, Azusa 1, Los Angeles 4, Signal Hill 2, Monterey 3, Santa Ana 1, San Bernardino County 1, San Bernardino 1, San Diego County 1, San Diego 3, San Joaquin County 1, Santa Barbara 1.

German Measles

18 cases: Alameda County 4, Berkeley 1, Oakland 1, Los Angeles County 1, Long Beach 1, Los Angeles 3, Pasadena 3, South Gate 1, San Francisco 1, Stockton 1, Tulare County 1.

Influenza

13 cases: Berkeley 1, Contra Costa County 1, Glendale 1, Los Angeles 6, Pasadena 1, Santa Ana 1, San Francisco 1, Ventura County 1.

Malaria

18 cases: Oakland 1, El Dorado County 3, Pasadena 1, Solano County 2, Sonoma County 3, Tulare County 7, Porterville 1.

Measles

149 cases: Alameda 1, Oakland 13, Chico 1, Fresno 1, Kern County 5, Bakersfield 1, Lassen County 1, Los Angeles County 5, Alhambra 2, Huntington Park 1, Long Beach 16, Los Angeles 33, Pasadena 1, Pomona 1, South Pasadena 1, Ross 1, San Anselmo 1, Monterey County 2, Orange County 1, Brea 1, Fullerton 1, Orange 1, Corona 2, Sacramento County 1, Sacramento 1, Ontario 6, Chula Vista 1, Oceanside 4, San Diego 1, San Francisco 28, San Joaquin County 1, San Luis Obispo County 1, Arroyo Grande 1, San Bruno 1, Palo Alto 1. San Jose 1, Watsonville 1, Vallejo 1, Sonoma County 1, Yuba City 1, Red Bluff 1, Tulare County 1, Lindsay 1, Yolo County 1.

Mumps

221 cases: Alameda County 7, Alameda 1, Albany 4, Berkeley 18, Oakland 52, Pittsburg 1, Fresno County 2, Kern County 2, Corcoran 1, Hanford 6, Los Angeles County 5, Arcadia 1, Culver City 1, Glendale 1, Inglewood 1, Long Beach 1, Los Angeles 14, Pasadena 1, San Fernando 4, Maywood 1, Madera County 5, Marin County 5, San Anselmo 2, Mariposa County 1, Monterey County 4, Pacific Grove 1, Orange County 8, Fullerton 1, Sacramento 8, San Diego County 1, Coronado 1, San Diego 13, San Francisco 23, San Joaquin County 4, Stockton 6, Santa Barbara County 3, Santa Barbara 1, Santa Clara County 1, Palo Alto 1, Vacaville 1, Sonoma County 1, Dinuba 1, Tulare 3, Oxnard 2.

Pneumonia (Lobar)

38 cases: Berkeley 1, Kern County 1, Susanville 2, Los Angeles County 2, Culver City 1, Los Angeles 21, Santa Monica 1, Monterey County 1, Sacramento 2, San Bernardino County 1, Ontario 1, San Diego 1, San Francisco 2, Santa Paula 1.

Scarlet Fever

70 cases: Alameda 1, Oakland 1, Contra Costa County 1, Fresno County 1, Kern County 2, Lassen County 1, Los Angeles County 8, Glendale 1, La Verne 2, Los Angeles 19, Pomona 1, Santa Monica 1, Whittier 1, Lynwood 1, Fullerton 1, Santa Ana 1, Laguna Beach 1, Auburn 2, Sacramento 1, San Bernardino County 1, Ontario 1, San Diego 2, San Francisco 11, Stockton 3, Sunnyvale 1, Benicia 1, Sutter County 1, Lindsay 1, Visalia 1.

Smallpox

One case: Los Angeles County.

Typhoid Fever

23 cases: Butte County 1, Fresno County 3, Imperial County 1, Long Beach 1, Monterey County 1, Sacramento 1, San Diego 1, Sunnyvale 1, Shasta County 3, Sonoma County 4, Tulare County 1, Yolo County 1, California 4.*

Whooping Cough

174 cases: Alameda County 9, Alameda 2, Berkeley 10, Oakland 12, Contra Costa County 6, Kern County 1, Los Angeles County 8, Culver City 2, Long Beach 2, Los Angeles 26, Whittier 3, Orange County 2, Fullerton 1, Santa Ana 3, La Habra 2, Laguna Beach 1, Corona 4, Sacramento 9, San Diego County 2, San Diego 12, San Francisco 14, San Joaquin County 21, Stockton 7, Daly City 1, San Bruno 1, Santa Barbara County 3, Sonoma County 2, Ventura County 6, Oxnard 1, Yuba County 1.

Anthrax

2 cases: San Joaquin County 1, Benicia 1.

Dysentery (Amoebic)

2 cases: Oakland

Dysentery (Bacillary)

20 cases: Los Angeles 8, Pasadena 3, Monterey Park 2, Sonoma County 7.

Pellagra

One case: Long Beach

Poliomyelitis

3 cases: Kern County 2, Sacramento County 1.

Trachoma

4 cases: Fresno County 1, Los Angeles 1, Indio 2.

Encephalitis (Epidemic)

3 cases: Fresno County 1, Fresno 1, Yuba City 1.

Paratyphoid Fever

One case: Los Angeles County.

Botulism

One case: Los Angeles.

Trichinosis

One case: Los Angeles.

Jaundice (Epidemic)

One case: Alameda County.

Food Poisoning

6 cases: South Pasadena 1, Santa Barbara 5.

Undulant Fever

5 cases: Los Angeles 1, Merced County 1, San Bernardino County 1, San Francisco 1, Visalia 1.

Tularemia

One case: El Centro.

Coccidioidal Granuloma

4 cases: Kern County 1, Los Angeles County 1, Orange 1, Tulare County 1.

Septic Sore Throat

2 cases: Lake County.

Relapsing Fever

2 cases: El Dorado County 1, Sierra County 1.

Rabies (Animal)

12 cases: Kern County 1, Los Angeles County 1, Los Angeles 5, San Benito County 4, Santa Clara County 1.

"The whole end and object of education," said Aristotle, "is training for the right use of leisure." It is only recently, however, that the full practical import of this declaration has made itself felt. In the first place, the amount of leisure time has been increasing and seems destined to even more rapid increase in the near future. In the second place, urban civilization has disrupted traditional leisure pursuits and the individual's control over his own leisure, thus making necessary community action on the subject.—George A. Lundberg in Recreation.

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* Cases charged to "California" represent patients ill before entering the state or those who contracted their illness traveling about the state throughout the incubation period of the disease. These cases are not chargeable to any one locality.

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